CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Community Alternatives

(Amended After Comments)

907 KAR 1:044. Coverage provisions and requirements regarding community mental health center services.

RELATES TO: KRS 194A.060, 205.520(3), 205.8451(9), 422.317, 434.840-434.860, 42 C.F.R. 415.208, 431.52, 431 Subpart F

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 210.450, 42 U.S.C. 1396a-d,

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds[~~for the provision of medical assistance to Kentucky's indigent citizenry~~]. This administrative regulation establishes the coverage provisions and requirements regarding[~~for~~] community mental health center (CMHC) services.

Section 1. Definitions. (1) "Community mental health center" or "CMHC" means a facility which meets the community mental health center requirements established in 902 KAR 20:091.

(2) "Department" means the Department for Medicaid Services or its designee.

(3) "Enrollee" means a recipient who is enrolled with a managed care organization.

(4) **"Face-to-face" means occurring:**

(a) In person; or

(b) Via a real-time, electronic communication that involves two (2)-way interactive video and audio communication.

(5) "Federal financial participation" is defined in 42 C.F.R. 400.203.

(6)[~~(5)~~] "Provider" is defined by KRS 205.8451(7).

(7) "Qualified mental health professional" means an individual who meets the requirements established in KRS 202A.011(12).

(8)[~~(6)~~] "Recipient" is defined by KRS 205.8451(9).

Section 2. Requirements for a Psychiatric Nurse. A registered nurse employed by a participating community mental health center shall be considered a psychiatric or mental health nurse if the individual[~~he or she~~]:

(1) Possesses a master of science in nursing with a specialty in psychiatric or mental health nursing;

(2)(a) Is a graduate of a four (4) year nursing educational program with a bachelor of science in nursing; and

(b) Possesses at least one (1) year of experience in a mental health setting;

(3)(a) Is a graduate of a three (3) year nursing educational program; and

(b) Possesses at least two (2) years of experience in a mental health setting;

(4)(a) Is a graduate of a two (2) year nursing educational program with an associate degree in nursing; and

(b) At least three (3) years of experience in a mental health setting; or

(5) Possesses any level of education with American Nursing Association certification as a psychiatric or mental health nurse.

Section 3. Community Mental Health Center Services Manual. The conditions for participation, services covered, and limitations for the community mental health center services component of the Medicaid Program shall be as specified in:

(1) This administrative regulation; and

(2) The Community Mental Health Center Services Manual.

Section 4. Covered Services. (1) Services covered pursuant to this administrative regulation and pursuant to the Community Mental Health Center Services Manual shall include:

(a) **Rehabilitative mental health and substance use disorder services including:**

1.[~~Inpatient services;~~

~~(b) Outpatient Services;~~

~~(c)~~] Individual **outpatient** therapy;

2.[~~(d)~~] Group **outpatient** therapy;

3.[~~(e)~~] Family **outpatient** therapy;

4.[~~(f)~~ Collateral **outpatient[~~services including collateral~~]** therapy;

5.[~~(g) Intensive in-home services;~~

~~(h) Home visits;~~

~~(i) Emergency services;~~

~~(j) Personal care home services;~~

~~(k)~~] Therapeutic rehabilitation services**[~~ for adults;~~**

~~(l) Therapeutic rehabilitation services for children~~];

6.[~~(m) Evaluations, examinations, and testing including~~] Psychological testing;

7.[~~(n) Physical examinations;~~

~~(o) Services in a detoxification setting;~~

~~(p) Chemotherapy services;~~

~~(q)~~] Screening;

8.[~~(r)~~] An assessment;

9.[~~(s)~~] Crisis intervention;

10.[~~(t)~~] Service planning;

11.[~~(u)~~] A screening, brief intervention, and referral to treatment;

12.[~~(v)~~] Medication assisted treatment for a substance use disorder;

13.[~~(w)~~] Mobile crisis services;

14.[~~(x)~~] Assertive community treatment;

15.[~~(y)~~] Intensive outpatient program services;

16.[~~(z)~~] Residential crisis stabilization services;

17.[~~(aa)~~] Partial hospitalization;

18.[~~(bb)~~] Residential services for substance use disorders;

19.[~~(cc)~~] Day treatment;

20.[~~(dd)~~] Comprehensive community support services;

21.[~~(ee)~~] Peer support services; or

22.[~~(ff)~~] Parent or family peer support services**; or**

(b) Physical health services including:

1. Physical examinations; or

2. Medication prescribing and monitoring.

(2)(a) To be covered under this administrative regulation, a service listed in subsection (1) of this section shall be[~~Inpatient services, outpatient services, therapeutic rehabilitation services, emergency services and personal care home services shall be covered if the service~~]:

1.[~~(1) Is~~] Provided by a community mental health center that is:

a. Currently enrolled in the Medicaid Program in accordance with 907 KAR 1:672; and

b. Except as established in paragraph (b) of this subsection, currently participating in the Medicaid Program in accordance with 907 KAR 1:671; and

2.[~~; and~~

~~(2) Is~~] Provided in accordance with:

a. This administrative regulation; and

b. The Community Mental Health Center Services Manual.

(b) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the **fee-for-service** Medicaid Program**[~~ if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program~~].**

Section 5. Electronic Documents and Signatures. (1) The creation, transmission, storage, or other use of electronic signatures and documents shall comply with requirements established in KRS 369.101 to 369.120 and all applicable state and federal laws and regulations.

(2) A CMHC choosing to utilize electronic signatures shall:

(a) Develop and implement a written security policy which shall:

1. Be complied with by each of the center's employees, officers, agents, and contractors; **and**[~~and~~]

2. Stipulate which individuals have access to which electronic signatures and password authorization; **[~~and~~**

~~3. Identify each electronic signature for which an individual has access;~~][:]

(b) Ensure that electronic signatures are created, transmitted and stored securely;[~~and~~]

(c) Develop a consent form which shall:

1. Be completed and executed by each individual utilizing an electronic signature;

2. Attest to the signature's authenticity; and

3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and

(d) Provide the department with:

1. A copy of the provider's electronic signature policy;

2. The signed consent form; and

3. The original filed signature immediately upon request.

Section 6. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider, of any program in which the service is covered, **on [~~during~~]** the same **day of service[~~time period~~]**.

(2) For example, if a recipient is receiving a behavioral health service from an independently enrolled behavioral health service provider, the department shall not reimburse for the same service provided to the same recipient **[~~during the same time peri-~~**

~~od~~] by a community mental health center **on the same day of service**.

Section 7. Records Maintenance, Protection, and Security. (1) A provider shall maintain a current health record for each recipient.

(2) A health record shall:

(a) Include:

1. An identification and intake record including:

a. Name;

b. Social Security number;

c. Date of intake;

d. Home (legal) address;

e. Health insurance information;

f. Referral source and address of referral source;

g. Primary care physician and address;

h. The reason the individual is seeking help including the presenting problem and diagnosis;

i. Any physical health diagnosis, if a physical health diagnosis exists for the individual, and information**, if available,** regarding:

(i) Where the individual is receiving treatment for the physical health diagnosis; and

(ii) The physical health provider; and

j. The name of the informant and any other information deemed necessary by the independent provider to comply with the requirements of:

(i) This administrative regulation;

(ii) The provider's licensure board;

(iii) State law; or

(iv) Federal law;

2. Documentation of the:

a. Screening;

b. Assessment;

c. Disposition; and

d. Six (6) month review of a recipient's treatment plan each time a six (6) month review occurs;

3. A complete history including mental status and previous treatment;

4. An identification sheet;

5. A consent for treatment sheet that is accurately signed and dated; and

6. The individual's stated purpose for seeking services;

(b) Be:

1. Maintained in an organized central file;

2. Furnished to the Cabinet for Health and Family Services upon request;

3. Made available for inspection and copying by Cabinet for Health and Family Services' personnel;

4. Readily accessible; and

5. Adequate for the purpose of establishing the current treatment modality and progress of the recipient; and

(c) Document each service provided to the recipient including the date of the service and the signature of the individual who provided the service.

(3) The individual who provided the service shall date and sign the health record on

the date that the individual provided the service.

(4)(a) Except as established in paragraph (b) of this subsection, a provider shall maintain a health record regarding a recipient for at least five (5) years from the date of the service or until any audit dispute or issue is resolved beyond five (5) years.

(b) If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this subsection, pursuant to 42 C.F.R. 431.17, the period established by the secretary shall be the required period.

(5) A provider shall comply with 45 C.F.R. Part 164.

(6) Documentation of a screening shall include:

(a) Information relative to the individual's stated request for services; and

(b) Other stated personal or health concerns if other concerns are stated.

(7)(a) A provider's notes regarding a recipient shall:

1. Be made within forty-eight (48) hours of each service visit; and

2. Describe the:

a. Recipient's symptoms or behavior, reaction to treatment, and attitude;

b. Therapist's intervention;

c. Changes in the treatment plan if changes are made; and

d. Need for continued treatment if continued treatment is needed.

(b)1. Any edit to notes shall:

a. Clearly display the changes; and

b. Be initialed and dated.

2. Notes shall not be erased or illegibly marked out.

(c)1. Notes recorded by a practitioner working under supervision shall be co-signed and dated by **a licensed[~~the~~]** supervising professional**[~~ providing the service~~]**.

2. If services are provided by a practitioner working under supervision, there shall be a monthly supervisory note recorded by the supervising professional reflecting consultations with the practitioner working under supervision concerning the:

a. Case; and

b. Supervising professional's evaluation of the services being provided to the recipient.

(8) Immediately following a screening of a recipient, the provider shall perform a disposition related to:

(a) **A provisional[~~An appropriate~~]** diagnosis;

(b) A referral for further consultation and disposition, if applicable; **or[~~and~~]**

(c)1. **If applicable,** termination of services and referral to an outside source for further services; or

2. **If applicable,** termination of services without a referral to further services.

(9)(a) A recipient's treatment plan shall be reviewed at least once every six (6) months.

(b) Any change to a recipient's treatment plan shall be documented, signed, and dated by the rendering provider.

(10)(a) Notes regarding services to a recipient shall:

1. Be organized in chronological order;

2. Dated;

3. Titled to indicate the service rendered;

4. State a starting and ending time for the service; and

5. Be recorded and signed by the rendering provider and include the professional title (for example, licensed clinical social worker) of the provider.

(b) Initials, typed signatures, or stamped signatures shall not be accepted.

(c) Telephone contacts, family collateral contacts not coverable under this administrative regulation, or other nonreimbursable contacts shall:

1. Be recorded in the notes; and

2. Not be reimbursable.

(11)(a) A termination summary shall:

1. Be required, upon termination of services, for each recipient who received at least three (3) service visits; and

2. Contain a summary of the significant findings and events during the course of treatment including the:

a. Final assessment regarding the progress of the individual toward reaching goals and objectives established in the individual's treatment plan;

b. Final diagnosis of clinical impression; and

3. Individual's condition upon termination and disposition.

(b) A health record relating to an individual who terminated from receiving services shall be fully completed within ten (10) days following termination.

(12) If an individual's case is reopened within ninety (90) days of terminating services for the same or related issue, a reference to the prior case history with a note regarding the interval period shall be acceptable.

(13) If a recipient is transferred or referred to a health care facility or other provider

for care or treatment, the transferring provider shall, if the recipient gives the provider written consent to do so, forward a copy or summary of the recipient's health record to the health care facility or other provider who is receiving the recipient **within ten (10) business days of the transfer or referral**.

(14)(a) If a **CMHC's[~~provider's~~]** Medicaid Program participation status changes as a result of voluntarily terminating from the Medicaid Program, involuntarily terminating from the Medicaid Program, a licensure suspension, or death of the provider, the health records **regarding recipients to whom the CMHC has provided services[~~ of the provider~~]** shall:

1. Remain the property of the **CMHC[~~provider~~]**; and

2. Be subject to the retention requirements established in subsection (13) of this section.

(b) A **CMHC[~~provider~~]** shall have a written plan addressing how to maintain health records in the event of the provider's death.

Section 8. Medicaid Program Participation Compliance. (1) A **CMHC[~~provider~~]** shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(2)(a) If a **CMHC[~~provider~~]** receives any duplicate payment or overpayment from the department, regardless of reason, the **CMHC[~~provider~~]** shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of

this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 9. Provider Eligibility. (1) To be eligible to provide, and be reimbursed, for a service pursuant to this administrative regulation, a community mental health center shall be:

(a) Currently enrolled in the Kentucky Medicaid Program in accordance with 907 KAR 1:672; and

(b) Except as established in subsection (2) of this section, currently participating in the Kentucky Medicaid Program in accordance with 907 KAR 1:671.

(2) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid Program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid Program.

Section 10. Third Party Liability. A provider shall comply with KRS 205.622.

Section 11. Auditing Authority. The department shall have the authority to audit any:

(1) Claim;

(2) Medical record; or

(3) Documentation associated with any claim or medical record.

Section 12. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 13. Appeal Rights. (1) An appeal of an adverse action by the[~~a~~] department [~~decision~~] regarding a [~~Medicaid~~] recipient who is not enrolled with a managed care organization [~~based upon an application of this administrative regulation~~] shall be in accordance with 907 KAR 1:563.

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010[~~a department decision regarding a Medicaid provider based upon an application of this administrative regulation shall be in accordance with 907 KAR 1:671~~].

Section 14.[~~7.~~] Incorporation by Reference. (1) The "Community Mental Health Center Services Manual", December 2013[~~January 2008 edition~~], is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, 6th Floor West, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. or online at the department's Web site at http://www.chfs.ky.gov/dms/incorporated.htm.

907 KAR 1:044

REVIEWED:

Date	Lawrence Kissner, Commissioner Department for Medicaid Services

APPROVED:

Date	Audrey Tayse Haynes, Secretary Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation: 907 KAR 1:044
Contact person: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation establishes the coverage provisions and requirements regarding Medicaid Program community mental health center (CMHC) services.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish the coverage provisions and requirements regarding Medicaid Program CMHC services.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the coverage provisions and requirements regarding Medicaid Program CMHC services.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by establishing the coverage provisions and requirements regarding Medicaid Program CMHC services.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: The primary amendment authorizes CMHC to provide substance use disorder services (to all Medicaid recipients in contrast to the current scope of coverage which only includes pregnant women) and expands the scope of behavioral health services covered in a CMHC. Additional amendments include inserting various program integrity requirements such as requiring CMHCs to bill third parties for services if a third party is involved and not duplicate bill for a service provided to the recipient by another provider. Other amendments include establishing that CMHCs must comply with records maintenance/security requirements and Medicaid provider participation requirements. Another section is added to establish that the coverage of CMHC services is contingent upon federal approval and federal funding. Also, a section is added that clarifies that the Department for Medicaid Services has the authority to audit any claim, medical record, or documentation associated with any claim or medical record. Lastly, the appeals section is revised to establish that appeal rights regarding an adverse action in the realm of managed care will be as established in the relevant managed care organization administrative regulation (907 KAR 17:010, Managed care organization requirements and policies relating to enrollees.) The amendment after comments inserts a definition of “face-to-face” which accommodates Telehealth as qualifying as “face-to-face”; inserts a definition of “qualified mental health professional”; synchronizes the names of covered services with the terminology approved by the Centers for Medicare and Medicaid Services (CMS); eliminates a duplicative requirement regarding electronic signatures; and clarifies miscellaneous provisions.

(b) The necessity of the amendment to this administrative regulation: The primary

amendment – amendment related to substance use disorder services and behavioral health services – is necessary to comply with a federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." Additionally, the Department for Medicaid Services (DMS) is anticipating a substantial increase in demand for services as a result of new individuals gaining Medicaid eligibility in 2014. Some new individuals will be those eligible as part of the "expansion group" (a new eligibility group authorized by the Affordable Care Act which is comprised of adults under age sixty-five (65), who are not pregnant, whose income is below 133 percent of the federal poverty level, and who are not otherwise eligible for Medicaid.) Another newly eligible group is a group mandated by the Affordable Care Act comprised of former foster care children between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid benefits. Furthermore, DMS anticipates a significant enrollment increase of individuals eligible under the "old" Medicaid rules who did not seek Medicaid benefits in the past, but will do so as a result of publicity related to the Affordable Care Act, Medicaid expansion, and the Health Benefit Exchange. The Medicaid Program is required to ensure that recipients have access to services. Other amendments are necessary to enhance program integrity requirements, establish that provisions and requirements are contingent upon federal funding (in order to protect state taxpayer generated funds), and clarify appeal rights for Medicaid recipients. The amendment after comments is necessary to synchronize terminology with what was approved by CMS and to clarify policies.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by complying with an Affordable Care Act mandate, enhancing recipient access to services, enhancing program integrity requirements, protecting state taxpayer generated funds, and establishing appeal rights for Medicaid recipients. The amendment after comments will conform to the content of the authorizing statutes by ensuring that the terminology comports with federal requirements and clarifying policies.

(d) How the amendment will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by complying with an Affordable Care Act mandate, enhancing recipient access to services, enhancing program integrity requirements, protecting state taxpayer generated funds, and establishing appeal rights for Medicaid recipients. The amendment after comments will assist in the effective administration of the authorizing statutes by ensuring that the terminology comports with federal requirements and clarifying policies

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Community mental health centers will be affected by this amendment. Additionally, licensed psychologists, advanced practice registered nurses, licensed professional clinical counselors, licensed clinical social workers, licensed marriage and family therapists, licensed psychological practitioners, licensed psychological associates, certified social workers (master’s level), licensed professional counselor associates, and marriage and family therapy associates who wish to provide substance use disorder services or the enhanced behavioral health services (established in this amendment) while working for or under contract with

CMHC will also be affected by this administrative regulation. Medicaid recipients who qualify for substance use disorder services or the enhanced scope of behavioral health services will be affected by this amendment.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. CMHCs will need to ensure that they use the practitioners authorized in this administrative regulation (stated in the incorporated material) to provide the new scope of services (expanded behavioral health services and substance use disorder services) if the given CMHCs wish to expand their scope of services accordingly.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is anticipated as expanding the scope of services is voluntary.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). CMHCs will benefit by being authorized to provide more services. The expanded types of behavioral health practitioners/professionals will benefit by having more employment opportunities in which to provide services. Medicaid recipients will benefit by having enhanced access to behavioral health services including substance use disorder services.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: DMS is unable to accurately estimate the costs of expanding the scope of behavioral health services, including substance use disorder services, covered in community mental health centers due to the variables involved as DMS cannot estimate how many community mental health centers will choose to accordingly expand their scope of services nor how many Medicaid recipients will elect to receive the expanded scope of behavioral health services in community mental health centers. Additionally, some of the new services are expected to prevent Medicaid recipients from having to be admitted to an inpatient acute care hospital or psychiatric hospital (which are more expensive levels of care.) Thus, expanding the scope of such services could reduce Medicaid program expenditures in aggregate.

(b) On a continuing basis: The response in paragraph (a) above also applies here.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. Neither an increase in fees nor funding is necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? Tiering is not applied as the policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act, 42 U.S.C. 1396a(a)(10)(B), 42 U.S.C. 1396a(a)(23), 42 U.S.C. 1396d(a)(2).

2. State compliance standards. KRS 205.520(3) states: "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. Section 1302(b)(1)(E) of the Affordable Care Act mandates that "essential health benefits" for Medicaid programs include "mental health and substance use disorder services, including behavioral health treatment." 42 U.S.C. 1396a(a)(23), is known as the freedom of choice of provider mandate. This federal law requires the Medicaid Program to "provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services." Medicaid recipients enrolled with a managed care organization may be restricted to providers within the managed care organization’s provider network. The Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees and provides the federal funding for Kentucky’s Medicaid Program – has expressed to the Department for Medicaid Services (DMS) the need for DMS to expand its substance use disorder provider base to comport with the freedom of choice of provider requirement. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid Program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope. Expanding the provider base will help ensure Medicaid recipient access to services statewide and reduce or prevent the lack of availability of services due to demand exceeding supply in any given area. 42 U.S.C. 1396d(a)(2) requires Medicaid program coverage of: "(A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)(1)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)(1)) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (l)(2) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan."

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter than federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different re-

sponsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by the amendment to this administrative regulation as will any community mental health center owned by a local government agency.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The Department for Medicaid Services (DMS) is unable to project the impact of this amendment on revenues for state or local government agencies as it depends on how many community mental health centers that are owned by a government entity elect to expand their scope of services to include substance use disorder services and other new behavioral health services and on utilization of those services in such entities.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The response to question (a) also applies here.

(c) How much will it cost to administer this program for the first year? DMS is unable to accurately estimate the costs of expanding the scope of behavioral health services covered in community mental health centers due to the variables involved as DMS cannot estimate how many community mental health centers will choose to accordingly expand their scope of services nor how many Medicaid recipients will elect to receive the expanded scope of behavioral health services in community mental health centers. Additionally, some of the new services are expected to prevent Medicaid recipients from having to be admitted to an inpatient acute care hospital or psychiatric hospital (which are more expensive levels of care.) Thus, expanding the scope of such services could reduce Medicaid Program expenditures in aggregate.

(d) How much will it cost to administer this program for subsequent years? The response to question (c) above also applies here.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:044

Summary of Material Incorporated by Reference

The “Community Mental Health Center Services Manual”, April 2014 is incorporated by reference. This edition replaces the December 2013 edition. Revisions include deleting vendor information, such as fiscal agent name and address, which created a potential for inaccuracies. Claims submission information was also removed from this manual, since the purpose of this services manual is not to instruct CMHCs on how to bill and submit claims. CMHC services were re-categorized into two (2) groups: ‘Rehabilitative Mental Health and Substance Use Services’ and ‘Physical Examinations’; while the previous six (6) categories were deleted: ‘Therapeutic Rehabilitation’, ‘In-patient Care’, ‘Emergency’, ‘Personal Care Home Services’, ‘Intensive in-home Services’, and ‘Collateral Services’. Titles, definitions, and requirements of practitioners were changed to align this manual with the State Plan Amendment (SPA) that was approved by CMS. CMHC covered services were also adjusted to match the language in the SPA. Rather than listing the authorized practitioners in Section (IV), which contains all of the covered services, the authorized practitioners for each service are listed in the new Appendix II.

The revised manual contains sixty (60) pages.